COMMISSION TO ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES

MICHIGAN PUBLIC MEETING HIGHLIGHTS—AUGUST 28, 2014

The Commission to Eliminate Child Abuse and Neglect Fatalities held a public meeting in Plymouth, Michigan on August 28, 2014, from 8:00 a.m. to 4:30 p.m. at the Inn at St. John's. The purpose of this meeting was to gather national and state-specific information regarding child abuse and neglect fatalities. More than 200 people attended via teleconference or in person. This brief provides highlights from the meeting, including key presentation points on the following:

- State and federal data collection strategies
- Counting child maltreatment fatalities in Michigan
- Fatality reviews in Michigan
- Prevention strategies

U.S. Representatives Dave Camp (R–Mich.) and Sandy Levin (D–Mich.) were both present to discuss the history of the Protect Our Kids Act of 2012 and their hopes for the Commission's work. The meeting also included brief presentations by a parent advocate and a foster youth, who offered recommendations from their own experience with the child welfare system. Both asked the Commissioners to recommend increased funding for prevention services to support families in building protective factors *before* a crisis occurs. The parent advocate also described how she learned to navigate the child welfare system when her own children were removed, the importance of agency communication, and why parent voices are essential in policy and practice decisions.

A full transcript and meeting minutes will be available on the Commission's website at https://eliminatechildabusefatalities.sites.usa.gov/

STATE AND FEDERAL DATA COLLECTION STRATEGIES

This panel of experts discussed the complexities and uncertainties of our national data on child abuse and neglect fatalities (including issues around inconsistent definitions) and provided recommendations to improve our understanding of the scope and classification of child fatalities due to abuse and neglect.

- **Amy Smith Slep, Ph.D.,** of New York University presented work that was the result of a collaboration between herself, Dr. Richard Heyman, and the U.S. Air Force. To try and improve the consistency in decision-making about which cases of child maltreatment should be substantiated (e.g., counted), they developed standardized child maltreatment definitions, conducted field testing of the definitions and a computerized decision tool, and then performed a dissemination trial. Use of the finalized tool resulted in 90 percent reliability (e.g., agreement) as to which cases of suspected maltreatment—not specifically fatalities—should be substantiated. The computerized tool is currently being used in practice throughout the Defense Department to make decisions about substantiation.

- **Patricia Schnitzer, Ph.D.**, an epidemiologist at the University of Missouri, argued for redefining child abuse and neglect fatalities as a public health issue rather than a child protective services (CPS) issue. In a public health model, fatalities are "counted" as child abuse and neglect fatalities when they meet standardized/operationalized definitions; these definitions may or may not match those established by different agencies (e.g., CPS, legal). Therefore, a given death can be counted by the public health system as a fatality but not included in the current federal counting system (NCANDS). The counting is independent of any single agency. Dr. Schnitzer also recommended including at least two categories (e.g., *definite* and *probable*) to allow for a level of uncertainty. In a public health model, there is an emphasis on collection of data about risk factors. Importantly, a public health model allows for inclusion of all deaths, not only those known to CPS. Dr. Schnitzer indicated that the public health model is, scientifically, the best model for developing intervention and prevention strategies, and that it allows for improved monitoring of trends over time.
- **Steve Wirtz, Ph.D.**, an epidemiologist with the California Department of Public Health, discussed California's response to some of the counting issues the Commission has been hearing about. SB39 requires welfare agencies to count (and treat) any child death as a maltreatment fatality if any one of three agencies—CPS, law enforcement, or the medical examiner—determines that the death was due to child maltreatment. He strongly suggested that including near fatalities in review efforts would broaden our understanding of the risk factors and causes and inform prevention efforts. Dr. Wirtz suggested that changes could be made to existing systems such as NCANDS and NVDRS to obtain the case-specific risk information needed to inform prevention efforts. He also supported the role of child death review teams (CDRTs) to serve as multi-agency, multidisciplinary forums for reviewing and classifying child deaths and proposed funding a feasibility study to adapt the Air Force's current classification system for use by CDRTs.
- **Vincent Palusci, M.D., M.S.**, a professor of pediatrics at NYU Langone Medical Center, reinforced the call to look at child abuse and neglect fatalities as a public health issue. He emphasized the role of medical professionals, particularly pediatricians with expertise in child abuse, in improving identification and prevention strategies. He also argued for changes to HIPAA to enhance information-sharing. He recommended that CAPTA funding be expanded to require reviews and extend them beyond child welfare. Finally, he suggested an important role for CDRTs and recommended incorporating linked fatality-specific data elements into NCANDS and CDC data.

The panel presentation was followed by a demonstration and discussion of the Air Force tool and further discussion about the implications of looking at child maltreatment fatalities as a public health issue.

COUNTING FATALITIES IN MICHIGAN

Steve Yager, director of the state's Children's Services Administration (CSA), provided a high-level overview of the process of investigating and counting child maltreatment fatalities in Michigan, as governed by the state's Child Protection Law. Other speakers provided more in-depth views of specific elements of the system; these included representatives from CDRTs, medical examiners' offices, and a county prosecutor's office.

Panel members highlighted recent, promising changes in Michigan, including the following:

- A centralized intake system for reports of child death is providing greater consistency and quality control for investigation decisions.
- In many cases, law enforcement, CPS, and medical examiners' offices have protocols and informal relationships that support joint investigations.
- Strong local child death reviews allow DHS to collect comprehensive child-specific data.
- The state's new SACWIS system captures cause of death for individual child victims.
- The state is beginning to implement predictive analytics.

Presenters also identified the following areas where further improvements are needed:

- A more standardized approach to identifying cases for review
- Better strategies for defining, identifying, and tracking deaths due to neglect
- Funding to support further collaboration among law enforcement, CPS, and medical examiners when conducting investigations, as well as to fund more prosecutions
- Ongoing training to improve the quality of investigations by medical examiners' offices and child death review teams
- Public service announcements to increase reporting by the public

FATALITY REVIEWS IN MICHIGAN

A panel of speakers provided the Commissioners with an overview of the many different entities performing child death reviews in Michigan, including local and state advisory teams, citizens review panels, the Office of Children's Ombudsman, and the Office of the Family Advocate with DHS, as well as fetal and infant mortality reviews and the Domestic and Sexual Violence Prevention and Treatment Board. Several presenters emphasized the breadth of data used by these teams in making their determinations, including interviews with caseworkers and frontline staff in addition to case files from CPS, mental health, education, substance abuse, and law enforcement.

All 83 Michigan counties currently have local child death review teams. The state advisory team reviews local findings and makes annual recommendations to policymakers to prevent future deaths. Beginning in September 2014, the Office of Children's Ombudsman is authorized by new legislation to issue recommendations for how the state's legal and medical systems, in addition to CPS, can improve their ability to prevent child fatalities.

Presenters noted that many of their teams' recommendations have resulted in positive changes, including standardization of death scene investigations, improved safe sleep policy and practice, enhanced investigation of SUIDs, training for mandated reporters, a suicide prevention/depression management initiative for older youth in foster care, and mandatory training for child welfare workers on threatened harm assessment and safety planning. Michigan has reported a decline in child deaths during the past two years. Although Commissioners were cautioned that this cannot yet be interpreted as a trend, presenters did suggest an enhanced focus on safety within the state.

Panel members offered some recommendations to further improve the ability of child death review teams to reduce fatalities. These included the following:

- Increase federal funding to support child death review.
- Support greater collaboration with domestic violence agencies to enhance effectiveness of the community's approach in cases where this is a factor.
- Employ a public health approach to understanding and preventing child maltreatment deaths.

- Use public education to change cultural practices around neglect (e.g., unsafe sleep).

PREVENTION STRATEGIES

The Commission heard from a panel of state stakeholders about efforts to prevent child maltreatment fatalities. Stacie Bladen, acting deputy director of CSA, presented on Michigan's use of birth match, an automated system to identify children born to families who previously lost rights to a child or committed an egregious act of abuse and neglect. An automatic case assignment is made that requires workers to make an immediate contact to assess the safety and well-being of the infant, evaluate the risk of maltreatment, and provide services to protect children from harm.

Several presenters urged the Commission to recommend increased financial support for early, comprehensive, and sustainable prevention services. Specific approaches that panel members indicated are showing promise in Michigan include:

- Home visitation programs
- Use of a protective-factors framework
- The Period of PURPLE Crying program to prevent shaken baby syndrome
- Safe sleep education efforts
- Quality child care, including Head Start and Early Head Start
- Holistic, accessible, community-based services to families (e.g., Promise Neighborhoods)
- Tribal consultation meetings and agreements
- Culturally competent policies, procedures, training, and resources

A final panel presented brief overviews of their organizations' involvement in reducing child abuse and neglect fatalities and offered recommendations that they believed would help to reduce fatalities in the future. Some speakers reinforced points made earlier in the day (e.g., the need for community collaboration). Additional recommendations included the following:

- Integrate a health-equity lens within the Commission's analysis and recommendations.
- Do not rule out solutions that may be more difficult but will have longer-lasting results.
- Although greater emphasis is typically placed on physical abuse, keep in mind the lifelong detrimental effects of toxic stress and neglect.
- Encourage treatment of child maltreatment death as a national health emergency on the level of heart disease.
- Invest resources to build alliances with courts, business, faith communities, education systems, and other nontraditional partners for the purpose of prevention.
- Support universal use of valid, empirically supported assessment tools for structured decision-making.
- Make multidisciplinary teams (already required by CAPTA) a reality "on the ground."